

**Montana Medicaid Prior Authorization Request Form for Use of
Suboxone®, Zubsolv® (buprenorphine/naloxone) or Subutex® (buprenorphine)**

Coverage Restricted Exclusively for the Treatment of Opioid Addiction

Providers must submit their **Treatment Plan** before authorization will be considered.

At a minimum the **Treatment Plan** must include the following information:

- ☐ Documentation of assessment and screening for opioid dependence (DAST-10, DSM-IV)
- ☐ Documentation of opioid substance of abuse
- ☐ Documentation of proposed counseling schedule
- ☐ Documentation of proposed monitoring plan (urine drug screens, random pill counts, etc.)
- ☐ Copy of Controlled Substance/Treatment Contract which must include consequences for failure to comply

(Please note authorization limitations on page 2)

Patient's Name: _____ **Date:** _____

Patient I. D. Number: _____ **D.O.B:** _____

Physician's Name : _____

Physician's Phone # _____ **Physician's Fax Number:** _____

Drug/Dose Request: _____ (mg) **Daily Directions:** _____ (i.e.: 1 QD)

Is patient pregnant or nursing? _____ **If Yes, Due Date?** _____
(Note: If pregnant, documentation of a positive pregnancy test required to utilize Subutex®)

Signature of Physician: _____

DEA#: X- _____ **(Prescriber must have an X-DEA Number)**

Please complete form, attach documentation and fax to:
Medicaid Drug Prior Authorization Unit
1-800-294-1350

Important Notice

The attached information is **CONFIDENTIAL** and is intended only for the use of the addressee(s) identified above. If the reader of this message is not the intended recipient(s) or the employee or agency responsible for delivering the message to the intended recipient(s), please note that any dissemination, distribution or copying of the communication is strictly prohibited. Anyone who receives this in error should notify us immediately by telephone, toll-free at (800) 395-7961 or locally at 406-443-6002 and return the original message to us at the address above via U.S. Mail.

Montana Medicaid Suboxone®/Subutex/Zubsolv® Authorization Limitations

Covered Condition – Treatment of Opioid Addiction

Subutex®: Approvals will be limited to 5 days to allow for induction in the absence of a pregnancy diagnosis.

For pregnancy, Subutex® will be authorized only for the duration of pregnancy or nursing. Documentation of a positive pregnancy test is required at initiation and 4 months of therapy.

Maximum dose limitations for Suboxone® will apply.

Suboxone®/Zubsolv®:

- Patient must be 16 years or older.
- **Initial approval will be granted for 6 months. Dosing will be limited to maximum buprenorphine 24 mg/day for Suboxone® film and 17.1 mg/day for Zubsolv®. Requests for doses exceeding this will require provider documentation.**
 - **Documentation of compliance with counseling, drug screens (including buprenorphine and drugs of abuse), office visits must be provided for continued approval beyond the initial 6 months of therapy.**
- After 6 months, approval may be granted for additional 6 month intervals (with compliance updates) up to 18 months to allow for a total of 24 months of therapy. Dosing will be limited to maximum Suboxone® film 16 mg/day and 11.4 mg/day for Zubsolv®.
- Requests for dose increases will require provider documentation.
- Concurrent opioids, tramadol, or carisoprodol will not be covered. If a patient is Prior Authorized for Suboxone®/Subutex®/Zubsolv® after meeting all criteria and subsequently discontinues the medication, all opioids, tramadol formulations, and carisoprodol will remain on not-covered status. These medications will require Prior Authorization for any future prescriptions. Approval may be granted short-term for an acute injury, hospitalization, or other appropriate diagnosis only after the case is reviewed with the treating physician and the physician prescribing Suboxone®/Subutex/Zubsolv®.

Notes:

- 1. Approval may be cancelled by MT Medicaid at any time if patient fails to comply with Treatment Plan: failure to establish with and attend counseling sessions; missed or inappropriate results from drug screens; breaking controlled substance/treatment contract; provider dismissal.**
- 2. Change in provider will require complete new start documentation. Approval or denial will be dependent on rationale for the provider change.**



Montana Medicaid
Suboxone®/Subutex®/Zubsolv®-PA Requirements
Physician Chart Check List

Patient Name: _____
Patient ID: _____

Date of Birth: _____

☐ Copy of Assessment and Screening for Opioid Dependence (DAST-10, DSM-IV) or other supporting documentation

☐ Opioid Substance(s) of Abuse _____

☐ Psychosocial counseling referral made to _____

☐ Proposed counseling schedule* (weekly, q o week, etc) _____

☐ ****Patient informed that counseling is required. Documentation of active involvement in counseling must be submitted for continuation after initial 6 months of therapy.***

☐ Monitoring Plan (urine drug screens including buprenorphine and drugs of abuse, random pill counts, etc.)

☐ Copy of treatment contract signed by patient

If female, is patient pregnant? Yes ☐ No ☐

If yes, documentation of a positive pregnancy test is attached if Subutex® requested Yes ☐ No ☐

Will patients OB care provider be contacted? Yes ☐ No ☐

****Recommend interface with provider to establish post-delivery plan for newborn (treatment of neonatal withdrawal syndrome). There are no adequate or well-controlled studies of Suboxone®/Subutex® in pregnancy (Cat C)**

OB Provider: _____ **Date Contacted:** _____

Phone: _____

This checklist is designed to aid the provider in completing the requirements necessary to obtain Prior Authorization for the use of Suboxone®/Subutex®/Zubsolv® through Montana Medicaid. All requirements herein may be faxed to the Montana Medicaid Drug Prior Authorization Unit at 1-800-294-1350 along with the Prior Authorization for Suboxone®/Subutex® Request Form.